DERMAFILE™

Informed Consent for Dermafile™ Exfoliation Treatment

I: _____ Authorize: _____ performing service

at Business Name: _____to perform the

Dermafile™ Exfoliation Treatment(s).

Please Initial:

_____ I acknowledge that no guarantee has been made about the results of the procedure.

Although it is impossible to list every potential risk and complication, I have been informed of some possible benefits, risks and complications which may include, but are not limited to, the following:

* Provides a smoother appearance of the skin.
* Improves the appearance of fine lines an wrinkles.
* Helps to even the coloring and lighten the pigmentation of the skin.
* Supports the natural collagen syntheses in the skin.
* Helps to build collagen and thicken the dermis.
* Firms and tightens the skin.
* Reduces scaring and acne lesions.

May Cause:

* Redness dehydration peeling and swelling of the face.
* Skin to feel wind burned or sensitive for a few days.
* Mild scabbing on areas that have been worked on aggressively.

___ I attest that I have had an opportunity to ask questions and have questions answered to my satisfaction.

_____ I am over the age of eighteen, and have discussed any skin conditions or diseases, infection or cold sores with my esthetician or physician and understand that this procedure could result in a flare-up of these conditions.

_____ I give my permission for photographs to be taken to record my progress.

_____ These photos may be used for teaching or advertising purposes. I may request that my eyes be covered to conceal my identity.

_____ I agree to follow post treatment instructions.

Date: _____ Patient Signature: _____

Date: _____ Witness Signature: _____